Barriers and opportunities for shared decision making in clinical practice

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BACKGROUND & AIM

Shared decision-making (SDM): tool for **improving quality and responsiveness** of care through integration of knowledge and wishes of professional and patient in clinical encounters. Successful and sustainable **implementation remains difficult**.

Aim: contribute to meaningful implementation by analysing barriers and opportunities for SDM. Three elements:

1. overview of key characteristics of SDM,
2. overview of practical tools and how they fit with key characteristics SDM,
3. analysis of barriers and opportunities for implementation in clinical practice.

METHODS

- **literature review** on characteristics and tools,
- **Interviews** (83 interviews professionals & patients) and **observations** (13 applications tools & 3 moral case deliberations) in four departments of hospital in Amsterdam: neurology, psychiatry, emergency obstetrics and oncology.

Includes focus on intercultural differences and competences needed by professionals for applying SDM.

RESULTS

1 **Shared Decision Making**: existing definitions focus on a process in which the physician and patient go through multiple phases of decision-making in which they **share preferences** and **reach an agreement on treatment**. SDM holds the middle ground between a paternalistic and an informed decision making model, overcoming informational asymmetry between the physician and patients.

2

SDM Characteristics & Four groups of decision tools

SDM Characteristics \ Tools	Option Grids	GP training programs	Individualized Care Plan	Web-based decision tools
Information sharing	Not necessarily	Yes	Yes	Partly
Check understanding	Yes	Not necessarily	Yes	Yes
Discuss pros and cons	Yes	Yes	Yes	Yes
Joint decision	Yes	Not necessarily	Yes	Not necessarily
Reflection meeting	No	No	Yes	Yes

Barriers for implementation 3

All interviewed patients and professionals are supportive of the idea of implementing SDM, but have a broad range on perspectives on what SDM is, possible ways of implementation and practical barriers, and its feasibility.

Practical barriers, for instance:

- Lack of time for deliberation
- Professionals value medical information higher
- Professionals fear a loss of autonomy
- Professionals fear contradictory patient expectations
- Communication barriers (language, culture)
- Not all patient want new role, flexibility over standard SDM needed
- Information overflow of patients might occur
- Information is missing or hard to make available for patients
- Patients do not understand the offered information

Both parties need to be supported (training, information systems) to be able to have a meaningful deliberation on care and treatment.

CONCLUSION

Meaningful implementation of SDM can be **improved** by:

I. addressing lack of consensus between professionals on: what SMD means in practice, appropriate tools for implementation, whether proposed benefits might be applicable to specific treatment types.

II. Train competences (knowledge, attitude, skills) through: including competences for dealing with patient feedback in medical training, aligning with existing moral case deliberation practices.

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